COMMUNITY PERCEPTIONS OF
HEALTH PROBLEMS

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COMMUNITY PERCEPTIONS OF HEALTH PROBLEMS

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INTRODUCTION

The Department of Public Health in the City of Toronto has recently been reorganized. Based on the report Public Health in the 1980s, the City has been divided into four semi-autonomous Health Areas, as one means of relating more closely to the community (Figure 1). Each Health Area has been required to develop a set of program priorities based in part upon Area-specific data and upon local needs. As part of the process of assessing needs, it was felt important to develop some sense of the community's perceptions of the health problems faced by the community. This would supplement Area-specific socio-demographic, natality and mortality data and expert opinion. As interim Associate Medical Officer of Health in the Eastern Health Area, and later as Associate Medical Officer of Health in the Northern Health Area, I was involved in the planning and implementation of two of these surveys of community perceptions of health problems, and it is those two surveys that I am reporting on today.

The two communities are quite distinct, as shown on the maps (Figures 1 and 2). The Eastern Health Area (EHA), with a population of roughly 125,000 tends to be of somewhat lower socio-economic status, except for the Beaches. There is a very high proportion of single mothers in the EHA. The Northern Health Area (NHA) with a population of roughly 215,000, itself has two distinct communities - North Toronto is of high socio-economic status, with a high proportion of elderly, while Hillcrest is of lower socio-economic status with a large immigrant population, and many young children. Area-specific natality and mortality data did not disclose any startling health problems, though the SMR's for all causes of death, for cardiovascular disease and for male motor vehicle accidents were significantly lower in the NHA by comparison with Ontario, and significantly higher in the EHA for cirrhosis by comparison with the City.

The two surveys were conducted at two separate times - the one in the EHA in the spring of 1982, the one in the NHA in the fall of 1982 - due to the fact that the EHA was the first Health Area established, on a pilot basis.

METHODOLOGY

Two parallel surveys were conducted in each Health Area, one of all the staff working in the Area, and one of a panel of "community leaders". These people were chosen on the basis of their position, status, or role in the community (1). For this purpose, the two community health workers assigned to each Area were asked to develop a list of roughly 100 people. Certain criteria and target groups were specified. Forty percent or so were to be health/social service related, including physicians, other health practitioners and local service agencies. Sixty

percent or so were to be community leaders in the cultural, religious, service club, business, labour, political and general community service fields.

Phase I of the survey involved identifying a list of problems. A letter was sent to all staff and a separate letter with a stamped addressed return envelope was sent to each "community leader". The letter explained the purpose of the survey and the proposed methodology, and asked each individual to list "the top five health problems facing the residents of the community now and in the next ten years".

The first letter was followed up with a reminder letter. A third letter in the case of staff (and a phone call in case of community leaders) was sent to non-respondents in the EHA survey, but not in the NHA survey.

In Phase II, the responses of the staff and the community leaders were reviewed separately in each Area, and two problem lists were developed in each Area, one for staff and one for community leaders. These lists were then arranged alphabetically and sent to all staff and all community leaders (again with a stamped addressed return envelope) regardless of whether they had responded to Phase I. For each problem identified, they were asked to score the problem on a scale of 1 to 10, "1" meaning very unimportant, "10" meaning very important, and "0" meaning don't know, or no opinion. The questionnaire was followed up by two reminder letters, the first as a "thank you" letter to all participants for responding, the second to non-respondents expressing hurt and regret at the failure to respond.

The returned questionnaires were key-punched and the data analysed. Because of concern that an interpretation based on the scores assigned by each respondent would not allow for varying tendencies on the part of individual respondents to be either a "high scorer" or a "low scorer", each respondent's scoring was converted from an implicit to an explicit ranking, on a scale of 0-100. Then for each problem identified the mean rank was determined. My especial thanks go to Fred Goettler, the Department's biostatistician, who suggested the conversion from scoring to ranking and wrote the program to do this.

In the Eastern Health Area, the results of this first round of Phase II were tabulated and fed back to all respondents, in an attempt to undertake a Delphi-type process. However, very few respondents changed their opinion in this second round and hence there was minimal impact upon ranking. As a result, and in the interests of time and money, this second round was not carried out in the NHA. Also, in the EHA the results were tabulated by category of respondent (four types of staff - personal health/nursing; preventive clinical/medical-dental; environmental health/inspectors; support services/administration and clerical -

and two types of community leader - health and non-health), but this analysis was not felt to be very useful and was not carried out in the NHA.

RESULTS

The response rates are shown in Table 1. As can be seen, staff response rates were high in both Areas, and especially in the NHA, approaching 90%. The response rate from the community to Round 1 was comparable in both Areas, at around 60%, but in the EHA, fell to 41% in Round 2. The low response rate in the NHA to Phase I of the survey may be due to less intensive follow-up of non-respondents, since experience in the EHA had shown that few new problems were identified after the first twenty or thirty responses.

The four problem lists developed averaged 69 identified problems and were quite similar in content. They included medical, environmental and social concerns. The overall result of the four surveys are shown in Tables 2-3, which show the top quartile of ranked problems for staff (Table 2) and community (Table 3). The bottom quartile of ranked problems (in inverse order) are shown in Table 4 (staff) and Table 5 (community). A typical chart showing the range of ranking is shown in Figure 6.

In the EHA, the results were analysed by category of respondent. The top ten and bottom health problems for the six categories of respondents are shown in Tables 6-8.

DISCUSSION

It is important to recognize the weaknesses inherent in this survey. The community leaders were not randomly selected, and are not representative of the population living in the Health Areas. On the contrary, they were chosen precisely because it was felt that their position and role gave them an overview of the health and social problems being experienced by community residents.

Another shortcoming is the rather low response rate in the two community surveys. However, we can take some comfort from the fact that the response rate was approximately 60% in both surveys. Since we were not attempting to gain a definite measure of community health status, but simply a sense of the opinion of community leaders to supplement our data and expert opinion, the lack of representativeness and the low community response rate is not a major problem.

The most striking finding of these two surveys, carried out among separate communities and at separate times is the very high degree of agreement as to what constitutes the major health problems

facing the community. This is particularly striking in the case of the two community groups. where the degree of agreement is almost uncanny. Several other points are worth noting:

a) While it is possible that the top ranking given to stress by the staff may reflect their evaluation of their personal stress levels arising out of reorganization, it is noteworthy that both community groups rank stress second in importance.

b) While both staff groups rank various problems of the elderly high, it is clear that this is perceived as a much greater problem in the NHA, perhaps reflecting the higher proportion of seniors, or perhaps reflecting the existence in the EHA of Seniors' Link, a coordinated community service for the elderly not available in the NHA.

c) The higher ranking given by EHA staff to smoking, heart disease and cancer may be influenced by the school smoking prevention program which is being piloted in that Area, and by the primary prevention program also tested in that Area.

d) Both staff groups ranked teen pregnancy, alcohol abuse, child abuse and depression roughly equally, but the NHA did not list poor nutrition or drug abuse in the top quartile, and the EHA did not list lack of day care facilities in the top quartile.

e) Both community groups ranked unemployment as the number one threat to health, while the staff groups ranked it as sixth and ninth. Economic problems were also ranked high by the two community groups.

f) Clearly, the community groups do not perceive the problems of the elderly to be as serious as do the staff. In the NHA, reference by the community to the elderly only occurs at the tenth ranking, and in the EHA the elderly do not appear at all in the top quartile.

g) Equally clearly, the staff do not perceive mental illness and the community placement of ex-psychiatric patients as being as important a problem as do the two community groups.

h) Certain problems related to families are ranked more prominently by the community, including family instability and single parent families (NHA) and domestic violence and behavioural problems in adolescents (EHA). Only in the EHA do staff rank such problems in the top quartile, listing child abuse and poor parenting, though both staff groups also rank child abuse.

i) Isolation and loneliness are noted by all four groups. The staff rank the problem higher than do the community, though the EHA do so in reference specifically to the elderly.

REFERENCES

Nix, Harold. The Community and Its Involvement in the Study - Planning - Action Process. Washington D.C., U.S. Public Health Service.

TABLE 1

RESPONSE RATES (%) FOR STAFF AND COMMUNITY SURVEYS, EHA AND NHA

	EHA		NHA	
	STAFF	COMMUNITY	STAFF	COMMUNITY
N	119	102	109	124
PHASE I	90 (76%)	55 (54%)	42 (39%)	40 (32%)
PHASE II				
ROUND 1	93 (78%)	61 (60%)	97 (89%)	72 (58%)
ROUND 2	86 (73%)	42 (41%)	———	———

TABLE 2

COMMUNITY HEALTH PRIORITIES

IDENTIFIED BY STAFF
(TOP QUARTILE)

NORTHERN HEALTH AREA	EASTERN HEALTH AREA
1. Stress	1. Stress
2. Inadequate home care and support for elderly	2. Isolation of elderly
3. Inadequate housing for seniors	3. Smoking
4. Loneliness and isolation	4. Cardiovascular disease
5. Diseases of the elderly	5. Economic problems
6. Unemployment	6. Cancer
7. Teenage pregnancy	7. Child abuse
8. Heart disease	8. Drug abuse
9. Inaccessible health services for the elderly	9. Unemployment
10. Inadequate child day care facilities	10. Inadequate support for seniors
11. High blood pressure	11. Teen pregnancy
12. Alcohol abuse	12. Alcohol abuse
13. Child abuse	13. Depression
14. Smoking	14. Poor nutrition
15. Cancer	15. Unfitness
16. Lack of nursing homes	16. Poor parenting
17. Depression	17. Anxiety
18. Inadequate income for seniors	

TABLE 3

COMMUNITY HEALTH PRIORITIES

IDENTIFIED BY COMMUNITY
(TOP QUARTILE)

NORTHERN HEALTH AREA	EASTERN HEALTH AREA
1. Unemployment	1. Unemployment
2. Stress	2. Stress
3. Alcohol abuse	3. Drug abuse
4. Overuse of tranquilizers in women	4. Inflation and the economic situation
5. Smoking	5. Smoking
6. Inadequate services for ex-psychiatric patients in the community	6. Mental health problems
7. Drug abuse	7. Domestic violence
8. Economic hardship	8. Behavioural problems in adolescents
9. Mental illness	9. Alcoholism
10. Inadequate care & support service for seniors	10. Air pollution
11. Isolation and loneliness	11. Isolation and loneliness
12. Depression	12. Cancer
13. Family instability	13. Heart disease
14. Overprescribing by doctors	14. Teenage pregnancy
15. Lack of chronic home care programs	15. Health program cut-backs
16. Single parent families	16. Poor community acceptance of those with mental health problems
17. Air pollution	17. Poor eating habits
	18. Crime

TABLE 4

BOTTOM QUARTILE

OF HEALTH PROBLEMS

IDENTIFIED BY STAFF
(Inverse Priority)

NORTHERN HEALTH AREA	EASTERN HEALTH AREA
72. Dog excrement	66. Animal bites
71. Exposed garbage	65. Recreational accidents
70. Opting out	64. Relocation of problem groups
69. Soil pollution	63. Iatrogenesis
68. Lack of recreational facilities	62. Urban redevelopment
67. Poor control of animals (wild and domestic)	61. Glaucoma
66. Meaningless jobs	60. Resistance of pests to chemicals
65. Pesticide use	59. Industrial accidents
64. Dental disease	58. Hepatitis B
63. Schizophrenia	57. Rodent infestation
62. High C-Section rate	56. Cockroach infestation
61. Apathy	55. Hearing problems among children
60. Accidental injuries	54. Poor food store sanitation
59. Consumer/materialist lifestyle	53. Arthritis disorders
58. Inadequate preconceptual education	52. Home accidents
57. Lack of fitness programs	51. Noise pollution
56. Alzheimer's Disease	50. Increase in marginally incompetent adults
55. Inadequate occupational health services	

TABLE 5

BOTTOM QUARTILE

OF HEALTH PROBLEMS

IDENTIFIED BY COMMUNITY

(Inverse Priority)

NORTHERN HEALTH AREA	EASTERN HEALTH AREA
69. Sports injuries	69. Head lice
68. Coughs and colds	68. Tuberculosis
67. Inadequate podiatry services	67. Dog-related problems
66. Keeping "medical survivors" alive too often	66. Garbage on streets
65. Inadequate immunization	65. Rodent infestation
64. Poor health services for immigrants	64. Poor sanitation in restaurants
63. Inadequate prenatal care services	63. Inadequate immunization
62. Poor restaurant and food sanitation	62. Cockroaches
61. Infectious diseases	61. Poor quality medical care
60. Poor general hygiene	60. Noise pollution
59. Junk food	59. Uncaring and selfish population
58. Food additives	58. Illiteracy
57. Inadequate health care for infants and toddlers	57. Lack of V.D. clinics
56. "Senility"	56. Arthritis
55. Low back pain and back problems	55. Lack of physical fitness programs

TABLE 5 (cont'd)

54. Inadequate information on V.D.	54. Inadequate family planning services
53. Arthritis	53. Overemphasis on curative medical approaches to health problems
	52. Motor vehicle and other accidents

TABLE 6

PERSONAL HEALTH SERVICES - FINAL

1.	Stress	66.	Animal Bites
2.	Isolation and Loneliness in Old People	65.	Recreational Accidents
3.	Smoking	64.	Resistance of Pests to Pest Control Chemicals
4.	Teenage Pregnancy	63.	Rodent Infestation
5.	Child Abuse	62.	Relocation of Problem Groups to the Eastern Health Area
6.	Cardiovascular Disease	61.	Hepatitis B
7.	Anxiety	60.	Cockroach Infestation
8.	Poor Parenting Skills	59.	Urban Redevelopment
9.	Economic Problems	58.	Iatrogenesis
10.	Depression	57.	Industrial Accidents

PREVENTIVE CLINICAL SERVICES - FINAL

1.	Stress	66.	Animal Bites
2.	Drug Abuse	65.	Relocation of Problem Groups to the Eastern Health Area
3.	Smoking	64.	Recreational Accidents
4.	Dental Decay among Children	63.	Urban Redevelopment
5.	Poor Nutrition	62.	Resistance of Pests to Pest Control Chemicals
6.	Child Abuse	61.	Industrial Accidents
7.	Alcohol Abuse	60.	Iatrogenesis
8.	Unemployment	59.	Noise Pollution
9.	Sexually Transmitted Diseases	58.	Glaucoma
10.	Poor Parenting Skills	57.	Rodent Infestation

TABLE 7

ENVIRONMENTAL HEALTH & INSPECTION SERVICES - FINAL

1.	Economic Problems	66.	Iatrogenesis
2.	Cancer	65.	Hearing Problems among Children
3.	Smoking	64.	Glaucoma
4.	Cardiovascular Disease	63.	Inadequate Prenatal Care
5.	Sexually Transmitted Diseases	62.	Recreational Accidents
6.	Stress	61.	Increase in Marginally Incompetent Adults
7.	Water Pollution	60.	Inadequate Daycare Facilities
8.	Poor General Environmental Sanitation	59.	Dental Decay among Children
9.	Rodent Infestation	58.	Apathy
10.	Unemployment	57.	Urban Redevelopment

SUPPORT SERVICES - FINAL

1.	Isolation & Loneliness in Old People	66.	Animal Bites
2.	Cancer	65.	Relocation of Problem Groups to the Eastern Health Area
3.	Stress	64.	Iatrogenesis
4.	Drug Abuse	63.	Glaucoma
5.	Cardiovascular Disease	62.	Recreational Accidents
6.	Child Abuse	61.	Increase in Marginally Incompetent Adults
7.	Economic Problems	60.	Urban Redevelopment
8.	Unemployment	59.	Hepatitis B
9.	Crime	58.	Occupational Disease
10.	Depression	57.	Resistance of Pests to Pest Control Chemicals

TABLE 8

COMMUNITY HEALTH WORKERS - FINAL

1.	Inflation & the economic situation	69.	Head Lice
2.	Drug Abuse	68.	Tuberculosis
3.	Unemployment	67.	Poor quality medical care
4.	Stress	66.	Dog related problems
5.	Cancer	65.	Illiteracy
6.	Behavioural problems in adolescents	64.	Lead contamination
7.	Smoking	63.	Uncaring and selfish population
8.	Heart disease	62.	Garbage on streets
9.	Crime	61.	Noise pollution
10.	Alcoholism	60.	Rodent infestation

COMMUNITY LEADERS - FINAL

1.	Unemployment	69.	Head Lice
2.	Stress	68.	Rodent infestation
3.	Drug Abuse	67.	Garbage on streets
4.	Domestic violence	66.	Dog related problems
5.	Mental health problems	65.	Tuberculosis
6.	Inflation & the economic situation	64.	Poor sanitation in restaurants
7.	Smoking	63.	Inadequate immunization
8.	Air pollution	62.	Arthritis
9.	Alcoholism	61.	Cockroaches
10.	Water pollution	60.	Sedentary lifestyle

FIGURE 1

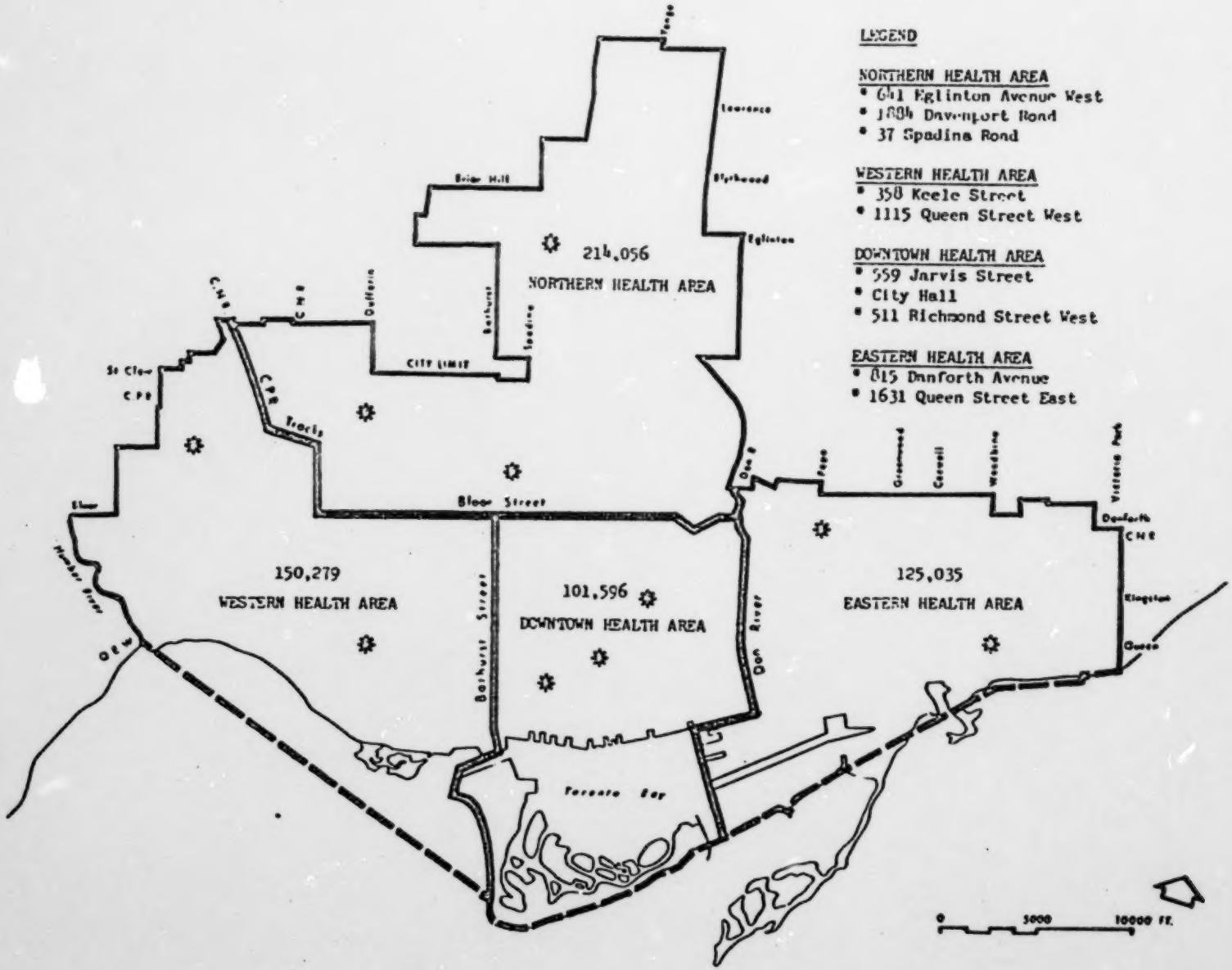
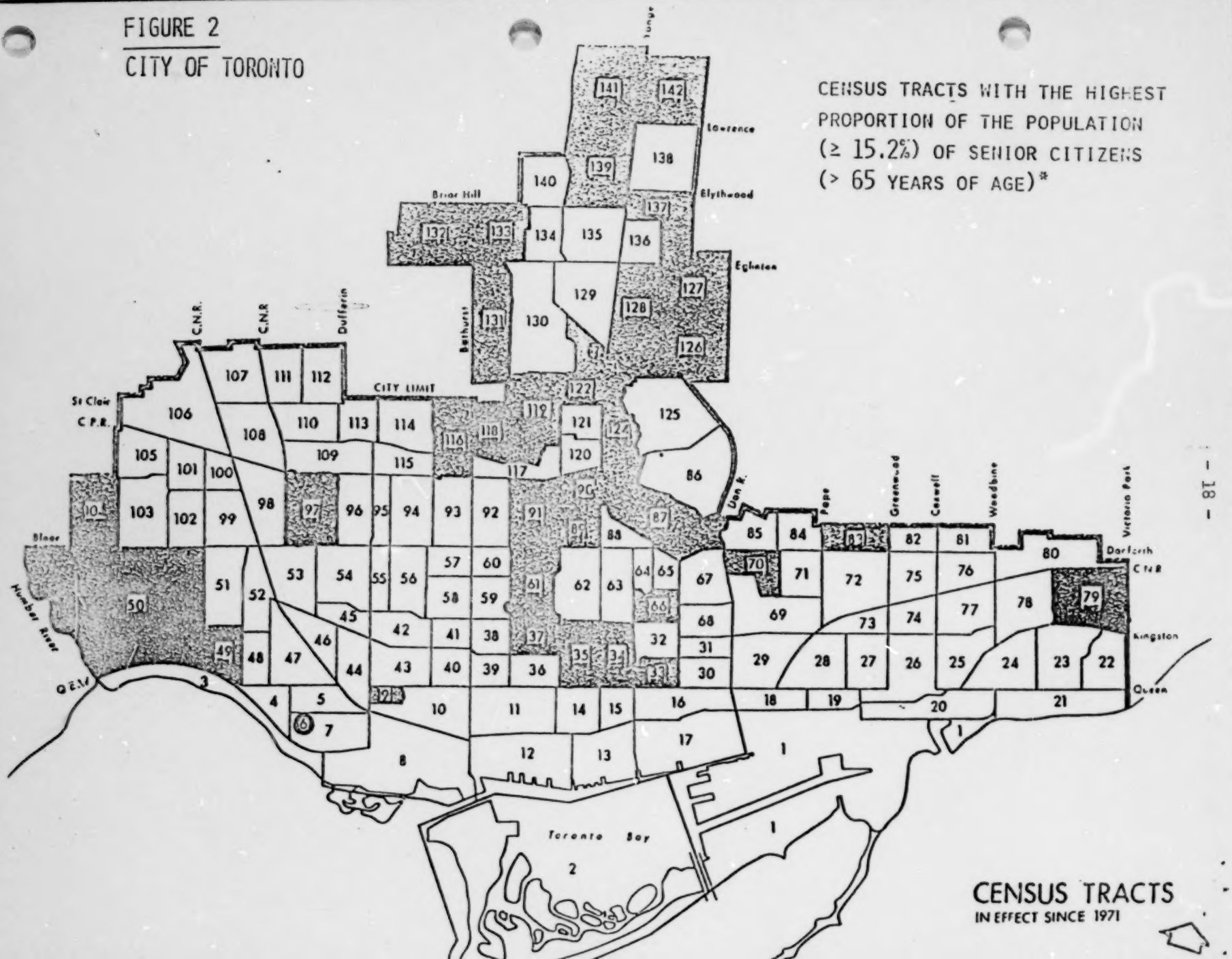

LEGEND
NORTHERN HEALTH AREA
• 641 Eglinton Avenue West
• 1804 Davenport Road
• 37 Spadina Road
WESTERN HEALTH AREA
• 358 Keele Street
• 1115 Queen Street West
DOWNTOWN HEALTH AREA
• 559 Jarvis Street
• City Hall
• 511 Richmond Street West
EASTERN HEALTH AREA
• 815 Danforth Avenue
• 1631 Queen Street East
214,056
NORTHERN HEALTH AREA
150,279
WESTERN HEALTH AREA
101,596
DOWNTOWN HEALTH AREA
125,035
EASTERN HEALTH AREA
CITY LIMIT
Bloor Street
Bathurst Street
Don River
Toronto Bay
Lawrence
Eglinton
Dufferin
Spadina
Jarvis
Parliament
Danforth
Queen
0
5000
10000 FT.

FIGURE 2

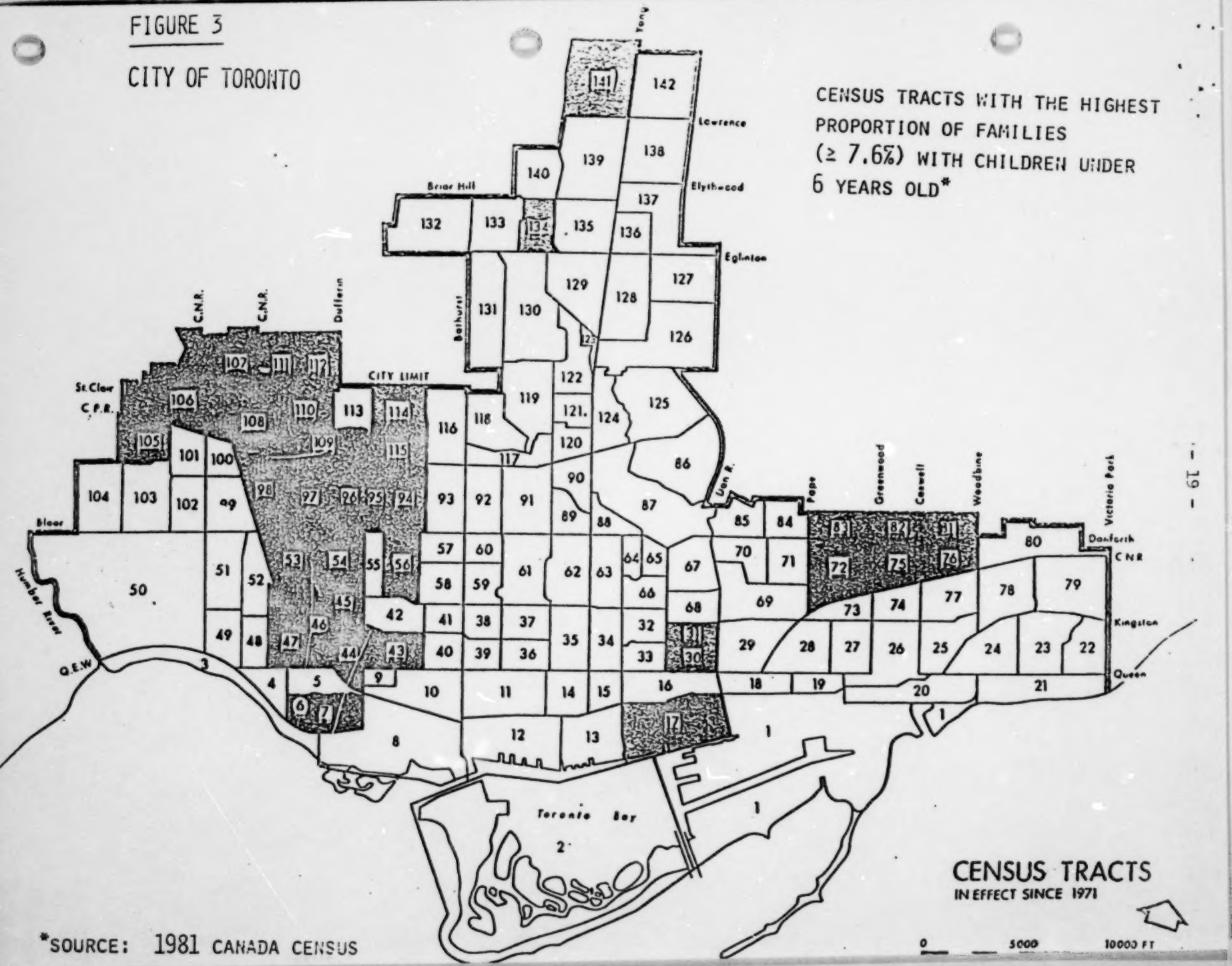
CITY OF TORONTO



SOURCE: 1981 CANADA CENSUS

FIGURE 3

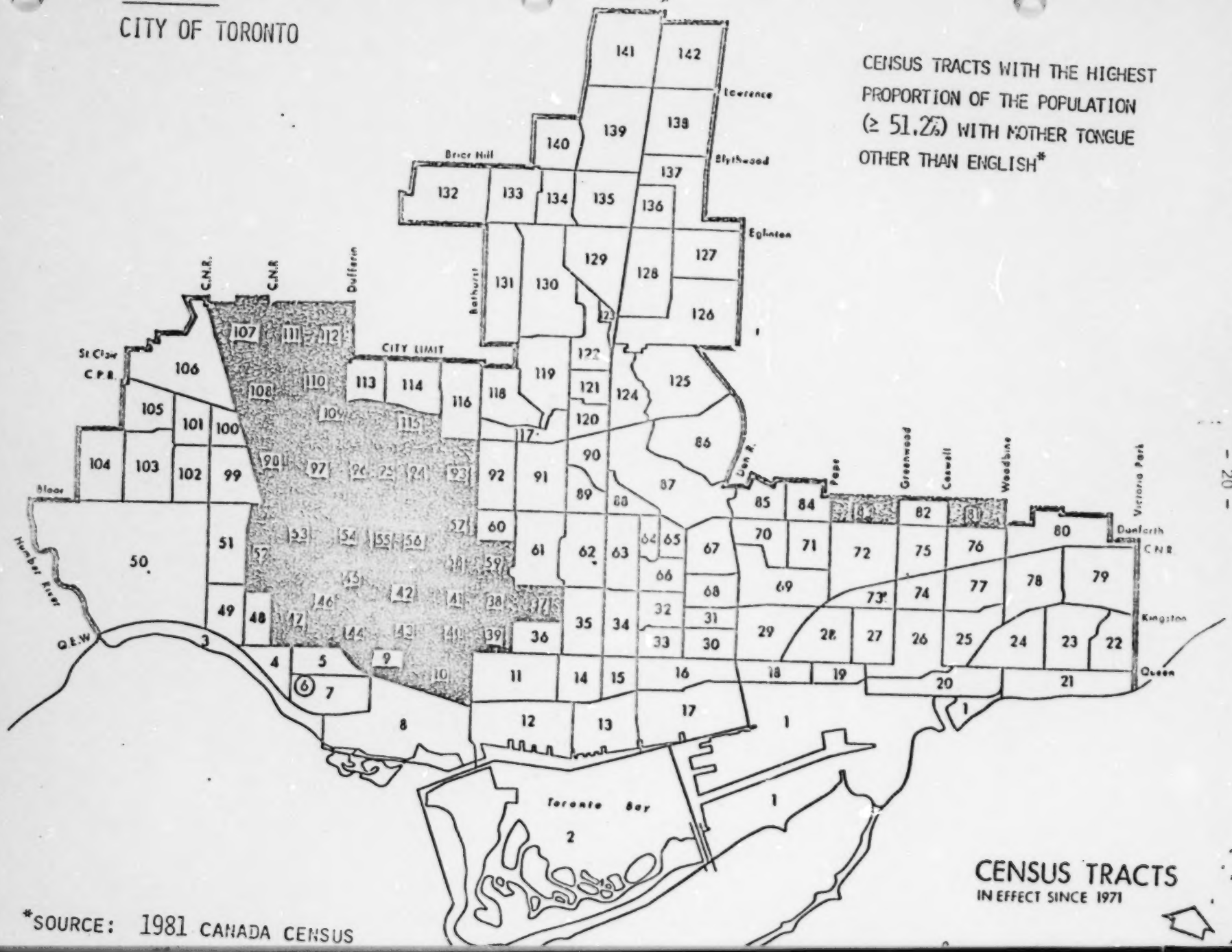
CITY OF TORONTO



*SOURCE: 1981 CANADA CENSUS

CITY OF TORONTO

CENSUS TRACTS WITH THE HIGHEST PROPORTION OF THE POPULATION (≥ 51.2%) WITH MOTHER TONGUE OTHER THAN ENGLISH*



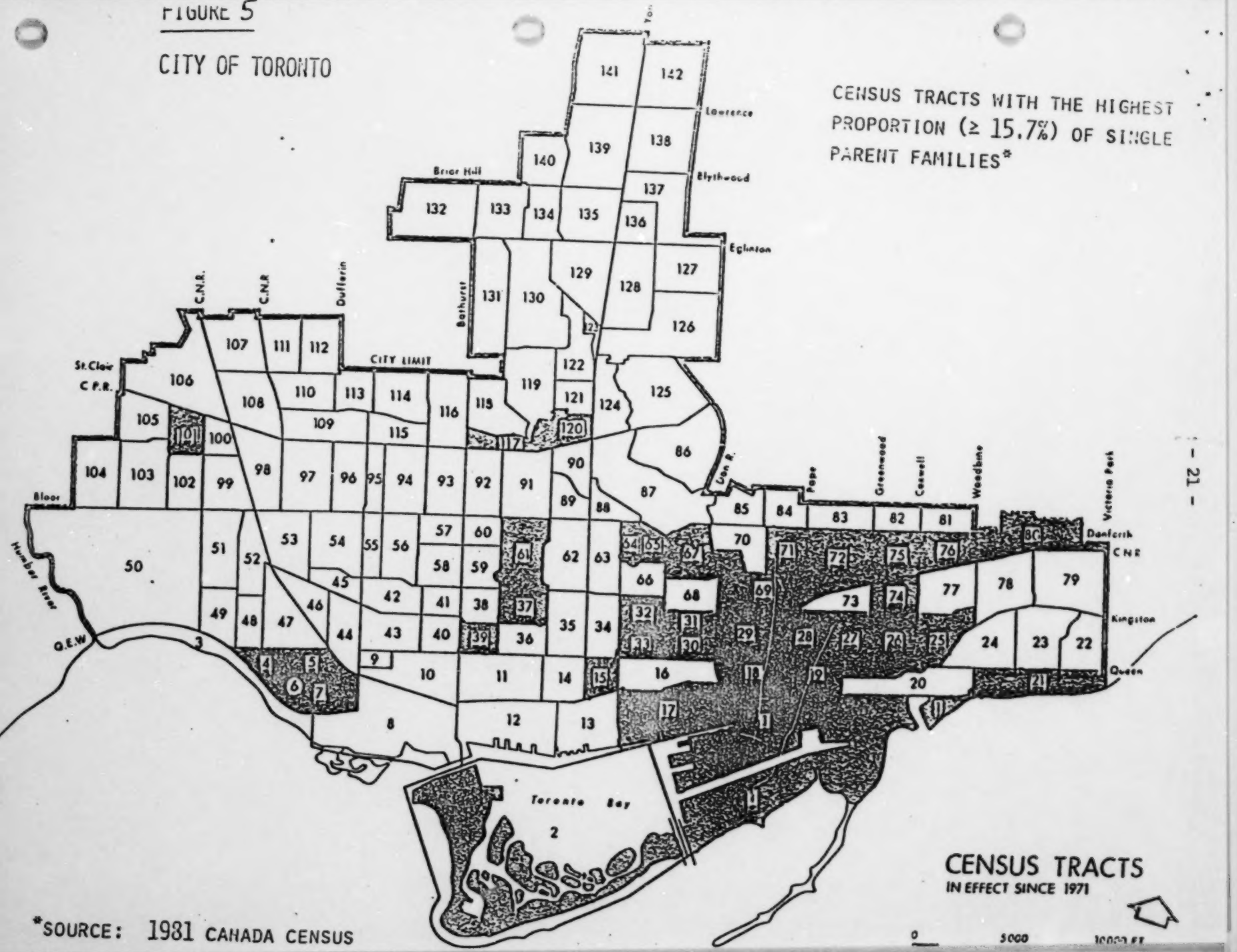
CENSUS TRACTS
IN EFFECT SINCE 1971

*SOURCE: 1981 CANADA CENSUS

FIGURE 5

CITY OF TORONTO

CENSUS TRACTS WITH THE HIGHEST PROPORTION (≥ 15.7%) OF SINGLE PARENT FAMILIES*



*SOURCE: 1981 CANADA CENSUS

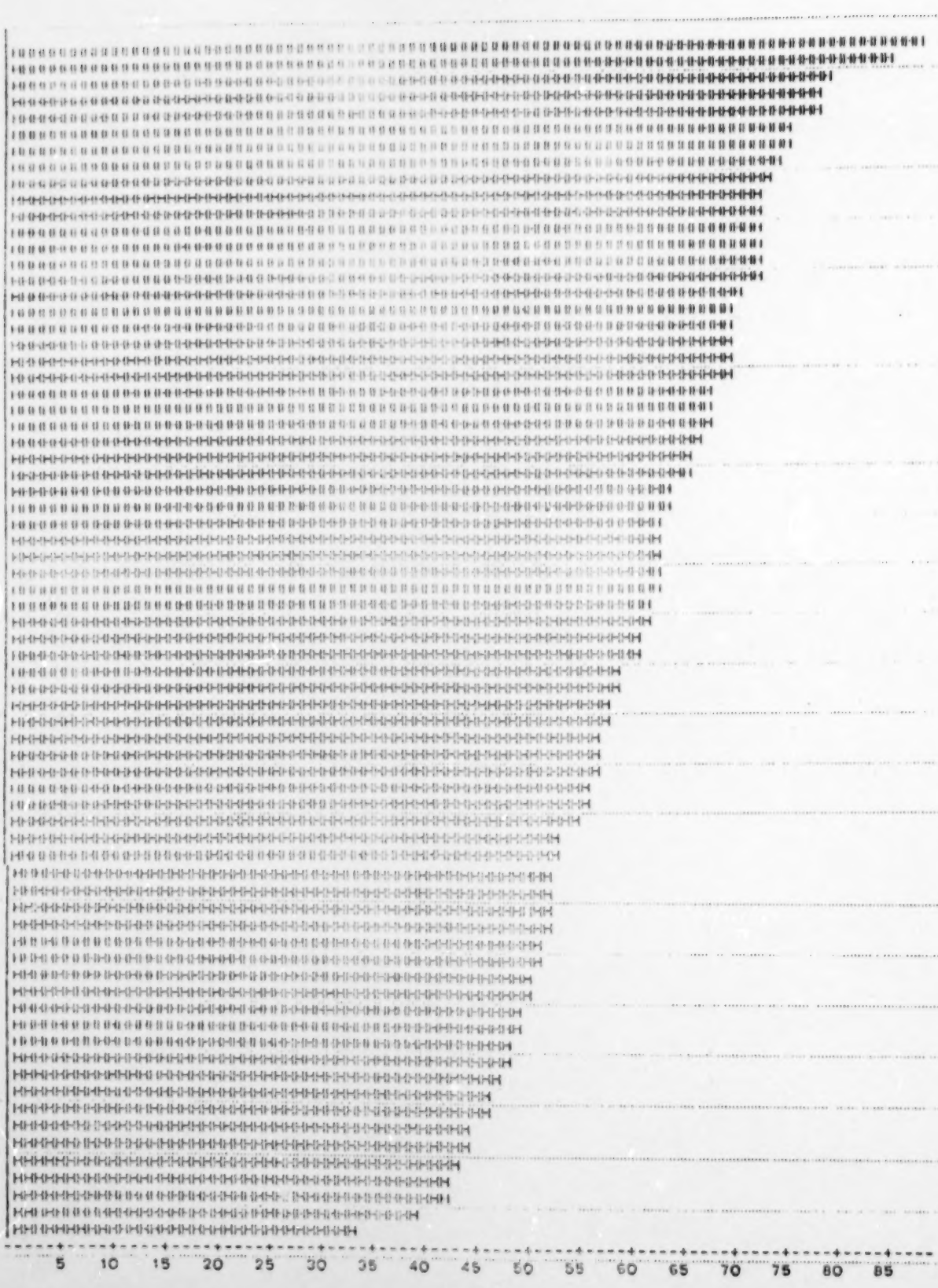
FIGURE 6

[illegible] HEALTH AREA

[illegible] HEALTH PROBLEM DELPHI SURVEY

[illegible] RESPONSES

BAR CHART OF RKMEAN



POOR

QUALITY

ORIGINAL